GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Health Regulation
& Licensing Administration

SENT via FACSIMILE and US MAIL

January 23, 2008

David Carrington
Director
Innovative Life Solutions
6475 New Hampshire Ave.
Hyattsville, Maryland 20783

RE: 3259 O Street, SE

Dear Mr. Carrington:

Please find enclosed a Statement of Deficiencies reports for federal certification and licensure. The reports enumerate deficiencies found as a result of a **monitoring survey** conducted on January 10, 2008. You are required to respond to each deficiency. Although a reasonable period of time may be allowed for actual correction of these deficiencies, it is imperative that your plan be signed with a specific date for anticipated completion and returned to this office prior to **February 4, 2007**. Since these reports are subject to public disclosure, it is necessary that the responses be indicated on the original forms (enclosed), and not on an attachment, except if submitting a copy of a policy change. NOTE: "Corrected" is not an accepted reply. The plan MUST also include the following.

- **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**

- **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**

- **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and**

- **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented.**

PLEASE NOTE: Plans of Correction not adhering to the above requirements will not be considered acceptable. Also, failure to submit acceptable plans, within the specified time frame, MAY result in the loss of Medicaid reimbursement.

If you have any questions regarding this matter, please contact Sheila Pannell, Supervisory Heath Services Program Specialist, Intermediate Care Facilities Division on (202) 442-5888.

Sincerely,

Patricia W. VanBuren
Program Manager

cc: Medical Assistance Administration
Department on Disability Services

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Health Regulation Administration

SAMPLE SELECTION FORM

Survey Period
From: January 9, 2008
To: January 10, 2008

Provider Name:	Innovative Life Solutions 3259 O Street, NE Washington, DC 20019	Provider Number:	09G -188

Names	Functional Level	Core	Add-On	Client Identifiers
Tymika Benefield	Mild	☒	☐	#1
Kim Davis	Severe	☒	☐	#2
Patrice Frazier	Moderate	☒	☐	#3
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

Ronald Tyson
Name

1/10/08
Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G188	A. BUILDING _____ B. WING _____	C 01/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE	3259 'O' ST, SE WASHINGTON, DC 20020

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W 000	INITIAL COMMENTS A monitoring survey to the September 26, 2007 recertification survey was conducted on January 9 and 10, 2008, to verify corrective actions identified in the facility's submitted plan of correction. The findings of this survey were based on observations at the group home, interviews with management and residential staff, and review of records both clinical and administrative to include the review of the facility's unusual incident reports.	W 000		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure and encourage one of the four clients residing in the facility an opportunity to exercise their rights to privacy. (Client #1 and #2) The findings include: The facility failed to ensure direct care staff protect clients' rights to privacy as evidenced below: 1. On January 9, 2008 at approximately 5:08 PM one of the direct care staff was observed to instruct Client #1 to complete her afternoon chores. Client #1 refused to complete her chores and proceeded to walk down the hallway, enter her bedroom and close the door. A few minutes	W 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 130	Continued From page 1 after entering the bedroom the Qualified Mental Retardation Professional (QMRP) was observed stand at Client #1's bedroom door, open the door and go into her bedroom. At no time prior to the QMRP entering the clients bedroom was he observed to knock on the bedroom door and/or ask could he enter her bedroom. Interview with the QMRP at approximately 11:00 AM on January 10, 2008 the QMRP agreed that he had not "pay attention" to Client #1's privacy before he entering her bedroom. Review of the personnel record revealed that the QMRP has been employed with the agency for approximately 3 months. Further review of the in-service training records revealed the privacy was a component covered in the agency's orientation for new employees. However this training was not effective. 2. On January 9, 2008 at approximately 5:13 PM. Client #2 was observed to leave her bedroom and come into the living room with her pajamas on in preparation for bed. At the time she entered the living room the picture window curtains were tide in a knot on both windows exposing the inside of the facility. Additionally, Client #2 was exposed to passing automobiles and pedestrians walking pass the facility. At no time did the direct care staff close the curtains to ensure the client's privacy while she sat in the living room in her pajamas.	W 130		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.	W 331		

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W 331	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's attending nurse failed to ensure the coordination of services one of the client's in the sample. [Client #1]. The finding include: On January 9, 2008 at approximately 3:40 PM, interview with the QMRP and the review of an unusual incident report dated 10/28/07 revealed that, Client #1 was taken to the hospital for chest pains. Later the same afternoon, interview with the nurse at approximately 5:00 PM via telephone revealed that several medical follow up appointment were to have occurred after the client was discharged from the emergency room. Further interview with the nurse revealed that all of the follow up appointments were completed and could be located in the Client #1's medical records. Review of Client #1's medical records revealed a consultation for Cardiology dated 11/28/07. The consultation findings indicated that the study had been completed and that the "Report to follow". Further review of the medical records failed to evidence the facility had secured a copy of the report for the primary care physician to review its findings. The next morning of January 10, 2007, over a months later, the nurse contacted the Cardiologist to fax the report to the facility. Review of the report did not evidence that the primary care physician had reviewed the findings of the study and/ or had made any recommendations for further treatment.	W 331		

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W 331	Continued From page 3 The was no evidence prior to the survey that the medical staff had received the Echocardiography report timely in order for the physician's to review the test findings. The facility's nursing staff failed to timely follow up on the results of Client #1's Cardiologist consultation. [See W322]	W 331		
W 454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a sanitary environment to avoid sources and transmission of infection. The finding includes: Observation on January 9, 2007 at approximately 4:24 PM direct care staff was observed at the dining room table braiding Resident 1#'s hair. At approximately 4:54 staff encouraged the resident's to come to the dining room table for dinner. Interview with QMRP revealed that the direct care staff most likely was braiding the resident's hair at the dining room table due to inadequate lighting in the living room. It should be noted that no lamp or lighting fixture was available in the living room.	W 454		

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R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. The finding includes: Review of the personnel records on January 10, 2008 at 11:30 PM revealed that the GHMRP failed to provide evidence that ensured criminal background checks were on file for two direct	R 125		

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R 125	Continued From page 1 care staff (MS and LN).	R 125		

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I 010	3501.1 ENVIRONMENTAL REQ / USE OF SPACE Each GHMRP shall provide a home-like atmosphere in a setting that is the least restrictive of the resident ' s rights, but yet will allow the resident to function safely and effectively. This Statute is not met as evidenced by: Based on observation and staff interview the facility failed to ensure an atmosphere which allow the client to function safely and effectively. The findings include: During an onsite inspection on January 9, 2008 at approximately 4:30 PM of the GHMRP environmental conditions revealed the following: The facility failed to have any lighting (i.e. lamp and or lighting fixture) in the living room area for the client usage and for their safe movement.	I 010		

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I 022	Continued From page 1	I 022		
I 022	3501.5 ENVIRONMENTAL REQ / USE OF SPACE Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure blinds and curtains at each window. The finding includes: On January 9, 2008 at approximately 4:30 PM curtains in the living room were tied in a knot. The windows had no covering and exposed the inside of the group home. Residents #1 was observed to go into her bedroom. Upon her return to the living room, she had changed into her pajamas. The resident then took a seat on the couch in front of the window. The entire time the client was seated in the living room at no time was the direct care staff observed to untie and close the curtains.	I 022		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observations, the GHMRP failed to maintain a safe,clean,orderly, attractive facility free from dirt and rubbish.	I 090		

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I 090	Continued From page 2 The finding includes: During the environmental inspection conducted on January 10, 2008 at approximately 10:30 AM, the GHMRP failed to ensure the following: Internal Their was no lamp in the living room area in order to provide adequate lighting for the residents. External The facility's front storm door was without a screen and/or glass to protect residents from the sharp metal edges of the storm door frame.	I 090		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees annually. The finding includes: Review of the personnel files conducted on January 10, 2008 at 11:20 AM, revealed that GHMRP failed to provide evidence of current signed job descriptions for one direct care staff [MS].	I 203		
I 204	3509.4 PERSONNEL POLICIES	I 204		

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I 204	Continued From page 3 Each employee shall be given a copy of his or her job description to review and sign at the beginning of employment. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all new employees. The finding include: Review of the personnel files on January 10, 2008, the GHMRP failed to provide current job descriptions for one new employees who had been employed for less that six month. (MS).	I 204		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform their required duties. The findings include:	I 206		

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I 206	Continued From page 4 Interview with the Qualified Mental Retardation Professional and review of the GHMRP's personnel files on January 10, 2008 at 11:30 PM revealed the GHMRP failed to provide evidence that current health certificates were on file for three (3) new direct care staff (LC, GM and MS).	I 206		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current training in CPR and First Aid for employees. The findings include: On January 10. 2008, review of personnel records/training records revealed that the following two new direct care staff are without current CPR and First Aid. (GM and KO)	I 227		